

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2011															
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2926 N CAPITOL AVE INDIANAPOLIS, IN 46208																	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE														
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of complaint numbers IN00099648 and IN00099720.</p> <p>Complaint number IN00099648: Substantiated, no deficiencies related to the allegations are cited</p> <p>Complaint number IN00099720: Unsubstantiated due to lack of evidence</p> <p>Dates of survey: November 21 and 22, 2011</p> <p>Facility number: 000567 Provider number: 155711 AIM number: 100289560</p> <p>Survey team: Vanda Phelps, RN, TC Michelle Hosteter, RN</p> <p>Census bed type:</p> <table> <tr><td>SNF</td><td>1</td></tr> <tr><td>NF</td><td>13</td></tr> <tr><td>SNF/NF</td><td>29</td></tr> <tr><td>Total</td><td>43</td></tr> </table> <p>Census payor type:</p> <table> <tr><td>Medicare</td><td>1</td></tr> <tr><td>Medicaid</td><td>42</td></tr> <tr><td>Total</td><td>43</td></tr> </table> <p>Sample: 3</p> <p>Highland Manor Healthcare was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the investigation of complaint numbers IN00099648 and IN00099720.</p>			SNF	1	NF	13	SNF/NF	29	Total	43	Medicare	1	Medicaid	42	Total	43	F 000			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Quality review completed 11/27/11 Cathy Emswiller RN			F 000			